Vol. 5
1941

July, 1941

BULLETIN OF THE MENNINGER CLINIC

AUG 1941

VOLUME 5

NUMBER 4

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TOPEKA
KANSAS

Issued bi-monthly by THE MENNINGER CLINIC, TOPEKA, KANSAS
Volumes begin with the January number. Annual subscription rate, $2.00
Single numbers, 30¢.

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Bulletin of
THE MENNINGER CLINIC

VOLUME 5 JULY, 1941 NUMBER 4

THE PSYCHOLOGICAL EXAMINATION: AN OUTLINE OF PROCEDURE IN THE DETERMINATION OF THE MENTAL STATUS OF THE PSYCHIATRIC PATIENT

BY WILLIAM C. MENNINGER, M.D., KARL A. MENNINGER, M.D., AND ROBERT P. KNIGHT, M.D.

In medical school the student receives very careful training in the technique of making a physical examination. Inspection, palpation, percussion, and auscultation become almost second nature to him. Likewise he spends many hours in learning the methods of chemical examination as applied to the fluids of the body—the urine, the blood, the spinal fluid, etc. But about the technique of the psychological examination of the patient he is taught practically nothing. In medical practice he soon finds that it is often as necessary to make a psychological examination as it is to make a physical examination, but because of his lack of training and his unfamiliarity with the technique of a formal procedure, he can do so only haphazardly and unscientifically. In this he is like the old-time physician who made his chemical examinations of the urine by the use of taste and smell.

Many physicians do not even know that there is an established technique of psychological examination although it has been in use by psychiatrists for forty years under the misleading title of the "Mental Examination." Now that physicians in other fields of medicine are more generally aware of the necessity for psychological examinations and the usefulness of a standard procedure, it seems appropriate to give the widest possible circulation to any scheme which has proved useful.

The psychological examination as used in psychiatry is based upon the assumption that there are certain intellectual, emotional, and behavior patterns characteristic of the individual which can be observed, recorded, compared with those of other persons, and the concurrencies and discrepancies indicated. Some of the reactions can be measured approximately, others of them quite accurately. The order in which data is collected and the details investigated in the explora-

tion of the various fields of mental activity have varied considerably in different psychiatric clinics. The scheme here presented is one which has been worked out over a period of twenty years at this clinic. The procedure has been changed many times; in fact it is constantly in the process of being modified and, we hope, improved.

For the sake of completeness the entire procedure of examination and testing is given, although various abbreviations are often necessary, especially in non-institutionalized cases. These are only suggestions and the examiner must use his judgment in modifying them for the individual patient. Although the outline should be followed rigorously in recording and organizing the data, it is rarely practicable to follow it systematically in obtaining them. A few specific questions to ask the patient are outlined, which may be quite appropriate with some patients and with others quite inappropriate. On many points valuable information can be obtained from observing the patient's relationships with other patients and through information gained from the nurses and therapists. It is generally best to begin by asking the patient to tell how he came to be here and from this go on to the life story, later filling in omissions in the family history, developmental history, school history, vocational, sexual and religious history.

In actual practice the young psychiatrist in training carries through the entire investigation as outlined except that the psychologist gives the special tests described under VIII. The experienced psychiatrist may not follow the procedure so closely. His familiarity with the various points in the comprehensive examination will enable him to estimate accurately some factors without specifically asking test questions, whereas other items may require careful scrutiny and questioning. The inexperienced examiner will need to take specific notes regarding his observations and the data supplied by the patient, but the experienced examiner may be able to record mentally sufficiently vivid and accurate impressions to enable him to dispense with note taking and rely upon his memory when he later dictates the material.

In recording observations and data, it is recommended that the following rule be utilized regarding the troublesome question of tenses:

The present tense is ordinarily used in physical examinations; it may be used in psychological examinations when a single specific episode

is to be described, but in making and recording a long psychological study such as here presented the present tense should be avoided and the imperfect and perfect (past) tenses used. Paragraphs or episodes in which the present tense is used for the purposes of vividness, clarity, or emphasizing the currency of the status described should be qualified with an introductory temporal phrase such as "At the present time. . . ."

I. General Observations

A. *Situation:* Describe the situation or situations existing at the time of various interviews, the circumstances under which the patient was seen, and whether in the doctor's office, in his room, in the living room, alone or with others present.

B. *Appearance:* Describe in general the personal appearance of the patient, including clothing (neat, careless, quiet, gaudy, shabby, costly), posture, manner (shy, bold, anxious, lively, surly, effusive, gentle, etc.), facial expression, mannerisms, fingernails, hair, cosmetics and modes of locomotion and carriage.

C. *Accessibility:* Describe the patient's acceptance of the interview, his varying attitudes toward the interviews, i.e., does he welcome them, tolerate them, refuse them, react to them with tears, etc. Describe also the manner of speaking, whether retarded, frank, evasive, coherent, relevant, meager, circumstantial, incoherent or excessive, rambling, business-like, reserved.

D. *Voice:* Loud, low, gutteral, well-modulated, resonant, nasal, strained, speech defect, etc.

E. *Reactions to examinations:* Verbal and behavior reactions to admission, physical examination, laboratory specimen collection, psychological tests and psychiatric conferences should be carefully observed and recorded. Levy's* "psychiatric-physical examination" should be used regularly with children.

II. Perception

A. *Alertness:* The extent to which the patient gives the examiner his attention, his cooperation, his grasp of the significance of the immediate situation should be noted. Describe the patient's perceptual acuity in terms of "very dull," "dull," "average alertness," "hypersensitive," and note the presence or absence of confusion and the degree in which it is manifested.

*Levy, David M.: A Method of Integrating Physical and Psychiatric Examinations. *Am. J. Psychiat.*, 9: 121–194, July 1929.

B. *Orientation:*

1. *Time:* Determine the patient's knowledge of the hour, year, date, day and season. In many instances the examiner may be able to judge these facts without direct questions, though in a surprising number of instances disorientation is actually demonstrated only by direct question, and often the inexperienced investigator assumes that because the patient "talks sensibly" about facts in general he is correctly oriented.
2. *Person:* Determine the patient's knowledge of his own identity and the names and stations of those about him (other patients, physicians, nurses, therapists, etc.).
3. *Place:* Determine the patient's knowledge of his whereabouts, the nature of the institution, its name and geographical location.

C. *Recent memory:* In estimating the reliability of recent memory consider both the patient's perceptual alertness and the short time retention. The patient should be queried regarding events in the immediate past: day or time of his arrival, companions and route of his trip, what has transpired since his arrival, new acquaintances, etc.

D. *Paresthesias:* Usually the examiner can initiate his inquiry by asking the patient about his physical health, how he "feels" about his body. This gives one the opportunity to inquire if he has had any non-organic tingling or queer sensations or hallucinatory tactile experiences.

E. *Illusions:* In all instances it is necessary to determine the authenticity of what seem to be false perceptions. Such information can be obtained from direct observation of the patient or from information obtained from the nurses or therapists; even the misidentification of voices heard in the hall, or of other sounds is worth noting. Psychopathological illusions ordinarily are not amenable to reason. The examiner may ask such additional questions as: "Is there anyone around here you have ever known before?" "What was your relationship to him previously, etc.?"

F. *Hallucinations:* The examiner must often use considerable tact in determining the presence of hallucinations; in other instances, the patient will voluntarily speak about them. But it is in those individuals who do not express them and may even deny them but in whom the examiner has reason to suspect their presence that his

questions about them must be couched in most tactful terms if he is to learn of their presence and character.

Thus, in auditory hallucination the examiner may start: "Have you ever had any very unusual experiences that you did not understand?" This may lead nowhere, but it gives background for the next question: "Have you ever heard any strange voices or noises from people you didn't see?" "What did they say?" or "What did they sound like—bells, hissing of steam, or what?" (If they were voices): "Did the voices seem to talk to you or about you?" Then the examiner should go on to determine the content of these hallucinatory experiences, whether they sounded material or spiritual, how the patient explained them, whether he regarded them as telepathic messages, the voice of God, etc.

Regarding *olfactory* hallucinations: One may ask such a question as: "Did you ever think you smelled bad odors, or poisonous gases that no one else could smell?" "Do you have this experience now or did it occur to you some time ago?"

Regarding *visual* hallucinations, one may ask: "Were you ever in anything like a trance?" "Did any of these seem real?" "Did you see people or objects that others couldn't see?" "What were they like?" "Did they move or stand still?" "Were they brightly colored?" "If they were people, were they very clearly seen?" "Did they seem to have a message for you, or threaten you or take notice of you?" "Did they have anything to say to you?" "What do you think the significance of that was?"

Regarding *gustatory* hallucinations: "Did you ever have a feeling that your food tasted peculiar?" "Did you ever have any feeling that it had been tampered with and you could detect bad tastes?" "Did you ever think that your cigarets tasted queer?" If the patient answers "yes" to these: "Did you ever think it was drugged?" If the answer is in the affirmative: "Who do you think might have put it there and why?"

Regarding *tactile* hallucinations: "Did you ever have peculiar sensations over your body?" "Where?" "Like what?" "Did you ever have an idea as to the origin or cause?"

Regarding *all* hallucinations, the examiner should determine how long such experiences have been going on, what ideas the patient has as to their purpose, their origin, their cause, the persons or things indirectly

involved, the results of the experiences; e.g., has the patient been led to action to stop them, to carry on communications with them? etc.

III. INTELLECTION

A. *Thought content:* Here record a brief summary of the patient's story of his life and especially of his illness. At least one or two significant paragraphs may advisedly be given in quotations, giving the physician's comments and questions and the patient's response.

B. *Remote memory:* The examiner can usually determine the accuracy and extent of the patient's remote memory from the patient's account of his childhood and earlier life.

C. *Delusions:* The presence of delusions will most likely have been divulged in the course of the life story. The examiner may supplement his information, however, by such questions as: "Do you have many friends?" "Does everyone treat you all right?" "Is everyone here nice to you?" "Was it right that you should have been sent here?" "Did you ever have any special difficulty with your friends?" "Do you feel that they have always treated you fairly?" "Do you think that anyone ever followed you or watched you?" "Do you think that people made up stories about you?"

The examiner may find it desirable to proceed with even more pointed questions as: "Did anyone ever try to harm you?" "Do you think anyone ever set out definitely to persecute you—Catholics, Masons, Ku Klux Klan?" "Do you ever feel that anyone has tampered with your food or tried to poison you?"

Quite often, especially in paranoid syndromes, the delusions are concealed, even denied, and must be inferred. Delusions of somatic nature are usually spoken about spontaneously by the patient and sometimes this may be only a matter of misinformation. The examiner should ascertain how the patient feels about his heart, lungs, stomach, bowels and genitals.

The presence of conscious guilt feelings should be sought for by such questions as: "Have you ever done anything seriously wrong?" "Do you think you have sinned more than other people?" If the answer is in the affirmative, the examiner must inquire into the nature of the "sins," whether they are "unpardonable," what the patient feels he should have done to him as the result of them.

D. *Obsessions:* Such questions as—"Do you ever have occasions when you are sure of something and yet doubt it?" "Do you have ideas that take charge of you?" "Does the same thought recur to you, or the same tune keep going through your mind?"—usually lead to an exposition of any prominent obsessions.

E. *Phantasies:* Phantasies are often extremely difficult to elicit from a patient, sometimes because the patient does not understand what the examiner wants to know but more often because he feels a little ashamed of them. Consequently, some leading questions are often helpful such as: "Do you ever imagine yourself going through situations before you meet them?" "Do you ever have thoughts as to what you would do if you were very powerful or rich?" "Just how would you change yourself or the world or both, if you could?"

Definitely sexual phantasies should be recorded under sexuality (Section IX).

F. *Dreams:* The examiner should specifically ask about the patient's dreams—outstanding dream, recurrent dreams, dreams of the night before, dreams upon special occasions. Ask whether the patient talks or walks or grinds his teeth in his sleep or awakens in terror.

G. *Intelligence:* In the older mental examinations simple tests known as the Masseloin, Ziehen, Finchk, etc. were frequently used. Methods for measuring intelligence are so much better standardized now that they are best included under special tests mentioned in Section VIII. The examiner may give his general impression here and compare it with the test results.

H. *Knowledge:* Distinguish between knowledge and the patient's ability to use it; i.e., intelligence. Knowledge can be estimated from the general mental content, but, in addition, the examiner may ask the patient about current events, politics, literature, history, etc.

I. *Judgment and insight:* The correctness of his estimates, opinions, interpretations, etc. of external objective matters is an index of the quality or freedom from impairment of the patient's judgment. Similar estimates regarding subjective matters constitutes insight. The latter is especially important in psychiatric examinations. The patient may not admit being sick (no insight); he may recognize that he has had a "nervous breakdown," or that he feels guilty or that he is depressed, but have no more than a superficial recognition of such facts without knowledge of their meaning

(partial insight). Or he may clearly recognize the severity of his illness and that something is fundamentally wrong with his personality.

In some instances it is practical to ask the patient about his mental functioning: "Do you think as clearly as you always have?" "Is your memory as good as it used to be?" "Has your illness affected your relationship to others?"

The concept of "judgment" developed in the earlier days of psychiatry is a rather vague term to describe the use of "common sense" in practical situations. The examiner must usually learn of this through the informants.

IV. Emotion

The word emotion is used in psychiatry with a great lack of precision to describe both a subjective experience and its objective expression. For the former we must rely on the patient's word; the latter we may interpret introspectively but of course with a wide margin of possible error. "Affect" is technically a better expression for the subjective experience.

A. *In trend:* The affect of the normal person varies with the situation and, therefore, cannot be said to have any definite trend. The psychiatrically ill person is apt to have a persistent emotional trend based on his disturbed adjustments. For practical purposes, we can regard anxiety as an undifferentiated affect response (although, technically, anxiety is probably not a specific emotion). As soon as the anxiety becomes differentiated emotionally, it appears as fear, sadness, anger or disgruntlement, despair, unjustified elation, frivolousness, etc. If one or several of these affects or moods appear to prevail more or less generally and more or less inpendent of the environment, specify them.

B. *Degree:* Specify also in approximate and relative terms the intensity of these trends.

C. *Appropriateness or disharmony:* The emotional reactions of the psychiatric patient are always somewhat inappropriate, as just described, in the sense of there being an incongruity between the way the patient feels and the situation he is in. However, a more important disharmony can often be detected between emotional expression and verbal expression or between emotional expression and behavior manifestations. A wide divergence between what the patient says or does, on the one hand, and how he appears to feel; i.e., the emotions he

expressed in his face, pupils, attitudes, etc. is pathognomonic of schizophrenia and should, therefore, be carefully appraised.

D. *Simulation:* The evaluation of emotional content is made more difficult by the ever present tendency toward simulation or play acting, which is in itself an emotional reaction related to the masochistic pleasure of exhibitionism. Forced gaiety, feigned indifference, and exaggerated mournfulness are typical pictures. One must try to evaluate to what extent the patient is attempting to display emotional reactions which he believes, intellectually, to be apropos, expedient or useful. The examiner must depend upon his impressions after long-time observation.

V. Action (Behavior)

These data are obtained by direct observation of the patient by the examiner and by the nurses, therapists, and attendants.

A. *Spontaneity:* What types of activities does the patient spontaneously initiate in the hospital situation?

B. *Range:* Where and under what circumstances are these carried out; alone or with other people, in his room or in the shop, etc.

C. *Impulsivity:* Describe the frequency and type of sudden, unexpected performances and activities, giving examples.

D. *Influenceability:* Is the patient easily influenced, difficultly so, or negativistic? Is a special approach or technique necessary or used? If so, what type and by whom? (Give specific examples.)

E. *Mannerisms and tics:* These, if slight, have probably already been mentioned under general observations; if severe, they should be more carefully described at this point. Mention of the conditions under which the movements are accentuated, diminished, or absent should be made.

F. *Compulsions:*

1. If the patient suffers from obsessions, describe here the activities associated with these obsessions, their nature, the frequency, apparent precipitating situations, etc.
2. Describe any compulsions or ceremonials in hand washing, door closing, dressing, excretory processes, walking, going to bed or arising, etc.
3. Describe any other evidences of compulsive character structure as indicated by particular orderliness of

room, clothes, drawers, arrangement of work, tendency to collect newspapers, paper, knick-knacks, rubbish, other objects, excessive emphasis on regularity or punctuality, or overcleanliness in dress, teethwashing, bathing, etc.

G. *Negativism:*
   1. Does the patient manifest perversity, refusals, stubbornness? If so, about what, toward whom, and under what circumstances?
   2. Does the patient ever evidence extreme degrees of negativism, mutism, catatonic posturing, refusal to walk or eat, or carry out other usual activities?
   3. Is there excessive idleness, "laziness," dawdling, etc.?

H. *Behavior in special treatment departments:*
   1. *In occupational therapy:* Does he go willingly, must be persuaded, report on his own initiative, etc.? What does he do or make? Degree of skill or proficiency? Willingness to accept instructions? Degree of dependency on therapist? Length of work period and his attitude toward this? For whom does he make his creations—himself, relative, therapist, hospital?
   2. *In recreational therapy:* Observe the following: Attitude toward prescribed activity. Cooperation with therapist, type of activity and his participation in its choice, degree of skill or efficiency, length of recreation period, response to group social activities—teas, parties, shows, etc.
   3. *In physiotherapy:* Procedures prescribed? His attitude toward each procedure? Attitude toward therapist? Degree of participation by patient in determining prescription? Behavior while in physiotherapy? Regularity and promptness in attending?
   4. *In educational therapy:* How does the patient react to educational opportunities? Types of classes in which he is interested? Efficiency, application, participation, persistence? Expressed attitudes? Assumption of responsibility?

I. *Eating habits:*
   1. Give facts regarding where patient eats (tube, spoon, in room, dining room, alone or with others); his appetite and general attitude toward food.
   2. Does the patient have pronounced likes and dislikes of food?

3. What peculiarities of manners and habits in eating has he?
4. Does he secrete food?
5. Attitude and habits regarding between-meal eating?
6. Attitudes, habits of beverage consumption—coca colas, coffee, beer, milk shakes, fruit juices, etc.
7. Does he demand or take much medicine? Kind?

J. *Smoking habits:*
1. Does he smoke a pipe, cigars, or cigarettes?
2. Does the patient smoke at all, moderately or excessively? (20 cigarettes a day might be considered moderately, 40 or more excessively.)
3. Does he seem to enjoy smoking or to do it only habitually or compulsively?
4. Has he outstanding peculiarities about smoking, such as the tendency always to borrow cigarettes or never to have a match, or always to discard the cigarette after a few puffs?
5. Is he careless with fire, ashes or stubs?
6. Does he have conscious conflict about smoking, attempting or threatening to discontinue it, etc.?

K. *Sleeping habits:*
1. Describe the patient's sleeping: average time of retiring, hours of sleep, nature of sleep (sound, fitful, restless, periods of being up, talking, nightmares, etc.), average time of arising.
2. What is the patient's idea about his sleeping—restfulness, soundness, etc.?
3. Does he require sedative? Types and amounts?
4. Does he sleep in the daytime?

L. *Excretory habits:*
1. What are the patient's bowel and urinary habits?
2. What are his ideas about these as to importance, regularity? Is he concerned about them?
3. Are there any apparent ceremonials in connection with them? Time spent on stool? Reading?

M. *Sexual habits as observed:*
1. Is masturbation overt or covert?
2. Flirtatiousness, petting?
3. Personal attachments—serious? realistic? aggressive?
4. Exhibitionism; verbal, genital, denudative?

N. *Menstruation:*
1. What are the facts regarding menstruation as observed regarding frequency, amount, duration?
2. What has been observed in the patient's behavior

regarding her management of menstruation—concern, cleanliness, cramps, medication?

O. *Character traits:* The examiner may choose here to describe the more outstanding behavior traits of the patient with some of the following non-technical, omnibus terms: 1) ambitiousness, 2) cautiousness, 3) cleanliness, 4) punctuality, 5) exhibitionism, 6) generosity, 7) gregariousness, 8) honesty, 9) independence, 10) studiousness, 11) suspiciousness, etc.

VI. Interpersonal Relationships

The bond between two individuals is a very complicated one consisting of positive and negative feelings emanating from both parties with variabilities in repression, stimulation, expression, etc. Each individual reacts to the way the other individual reacts to him, etc. It is, therefore, difficult to present a static account of interpersonal relations. An approximation may be achieved however by recording the attitudes of the patient toward the important persons in his immediate environment, especially his spouse, parents, siblings, children, employer, employees, fellow employees, and now also the other patients, nurses, the doctors and examining physician. His attitude toward the Sanitarium and finally, his attitude with respect to himself and his illness should be mentioned unless this is repetitious of material given under *Judgment and insight*.

In recording this material, the examiner should make a distinction between

A. Attitudes expressed verbally by the patient either to the relatives or to the examiner but without any conscious concealment.

B. Attitudes more or less secretly held and either not confessed at all or confessed only to intimate friends or to the examiner.

C. Attitudes inferred entirely from actions of the patient.

VII. Special Investigatory Procedures

A. *Free-association interview:* It is sometimes valuable to have the patient verbalize his thoughts without interruption, questioning, or other deliberate external stimulation. This may give a glimpse of foreconscious material including phantasies and ideational preoccupations not revealed in conversational and interrogatory interviews, or spontaneously without the encouragement of the free-association invitation and opportunity. For technical suggestions, see Felix Deutsch's "Associative Anamnesis."

B. *Hypnosis:* Occasionally hypnosis is more rapid and more productive than voluntary free-associational investigations of the fore-conscious and unconscious.

C. *Play technique:* With children often and with adults occasionally, it is helpful to use toys, first without and subsequently with suggested situations and set-ups, along lines described in detail by Homburger-Erickson, Melanie Klein, David Levy and others.

D. *Finger-painting and clay modeling:* The spontaneous comments and replies to questions of meaning referred to the spontaneous productions in finger-painting, clay and to a lesser extent in clay modeling and other art forms are frequently helpful in extending the information concerning foreconscious and unconscious trends, or in confirming the results of evidence concerning these derived by other techniques.

E. *Amytal, metrazol, alcohol and other intoxicants:* The spontaneous behavior or verbal communications of patients under the influence of various drugs are frequently quite different from those obtained by formal examination and observation in the undrugged state, and may prove valuable in formulating unconscious structures more definitely. Interrogation, suggestions, and other superinduced stimuli may assist this if skillfully applied.

VIII. Psychological Tests

These are administered by an experienced psychologist who should report the most pertinent findings to the examiner. (See Brown and Rapaport; "The Role of the Psychologist in the Psychiatric Clinic" *Bull. of Menninger Clin.* May, 1941 and references there given.)

A. *Standardized intelligence tests* (Merrill-Terman, Bellevue Adult Scale, and Babcock Deterioration): Attention is paid by the examiner to the discrepancy between the clinical impression of the patient's intelligence and his intelligence quotient as shown in the test, to the discrepancy between the results of the intelligence tests and the efficiency scores, and to the reported discrepancies between the scores of different test items. These discrepancies shed light on the influence of the emotional disturbance of the patient on his intellectual functioning.

B. *Projective personality tests* (Rorschach, Szondi, and Thematic Apperception): The value of these tests lies either in the corroboration of the clinical diagnosis or in deviations from it. When there are deviations the cause of the deviation is a subject for special investigation. Personality

trends indicated by these tests which did not appear in the clinical investigation also deserve further clinical scrutiny. The phantasy material elicited by the tests is especially helpful where the patient does not spontaneously communicate his phantasies.

C. *Concept formation tests* (B. R. L. Sorting, Weigl and Hanfmann-Kasanin): These give a cross section of the "personality in action" and thus give the pattern of the patient's behavior when he is confronted with a problem. The test is thus helpful in understanding the pattern of the activities of the patient as revealed in the case history.

D. *Topological tests* (Modified Dembo Technique, Level of Aspiration, and Zeigarnik): These show the patient's way of dealing with frustrating situations; they also give an insight into the degree of his self-esteem, and of the relative rigidity of the personality.

E. *Special testing procedures* (e.g., Visual-Motor Gestalt and Heinz Werner): These tests are used where psychic disturbances are believed to depend upon organic brain disease and special sensory disturbances.

IX. Sexuality

Much of the sexual history may be obtained from sources other than the patient. However, in the psychological examinations the examiner should attempt to determine all that he can about the attitudes and feelings of the patient regarding sex, as well as details of the actual experiences. In certain types of illness, notably schizophrenia, interrogation of the patient on this subject may be definitely contraindicated. Whatever data are obtained from the patient should be organized in chronological order thus:

A. *Pre-genital:* Include a brief account of the patient's pregenital experiences; e.g., nursing experiences, weaning, sphincter training, enuresis, infantile masturbation, etc.

B. *Conscious:* Give a brief account of the patient's conscious sexual life beginning with whatever he regards as his first sexual knowledge or experience and bringing it up to his own marital experiences, his own children, and his attitude toward them. Include any perverse experiences of adolescence or later. Comment on the patient's reaction to the interrogation.

C. *Unconscious:* Give as much of the patient's unconscious material—dreams, phantasies, symbolic acts, etc.—as can be related to known facts in the history or examination, and indicate which stage or stages of psychosexual development contribute most significantly to the characterology and symptomatology.

CHARTING IN A PSYCHIATRIC HOSPITAL

By William C. Menninger, M.D., F. Edmundson, R.N., and Bernice Johnson, R.N.

The accurate and intelligent recording of the hospital patient's daily activities and his reactions to these activities is of three-fold value: it furnishes information to the doctor, contributes to the education and professional growth of the nurse, and affords permanent records and legal protection to the hospital. It is the specific type of information supplied to the physician that differentiates the general hospital nurse's chart from the psychiatric hospital nurse's chart.

In the general hospital the nurse records the medication, the temperature-pulse-respiration observations, the time of dressings, the physician's visits, and the patient's physical comfort. This type of charting, however, is essentially useless in the psychiatric hospital where patients receive little or no medication and rarely show pathological variations in temperature, pulse and respiration. They are for the most part ambulatory, often participating in activities of various types, and the status of their bodily comfort is rarely a problem.

In the psychiatric hospital the desired information concerns three different aspects of the patient, his appearance, his behavior and his conversation, often referred to as the ABC of charting. Expressed in another way, it consists of what the nurse can see and hear from the patient, charted as accurately and as directly as possible. The doctor is especially dependent upon the chartist's observations, not only for directing individual treatment, but also for the accumulation of data which contribute significantly to a better understanding of the mental illness. It is usually impractical for a doctor to see a patient for more than an hour daily. In many institutions for the mentally ill, especially in state hospitals, the overcrowding of patients and the understaffing of physicians make even brief daily contact between patient and doctor impossible. Much of the physician's knowledge of the patient in any case depends upon observations made by the nurses who are with the patient during the entire twenty-four hours of each day. The great majority of the contacts between the physician

and the patient occur either in the patient's room or in the doctor's office, and because of the doctor's presence the patient is inclined to guard his behavior. The chart makes it possible for the physician to visualize the patient's habitual social behavior, as well as his reactions to other members of the hospital personnel. It permits him to know of the sudden transient peculiarities of action or speech which occur when he is not a witness.

It is often noted by the nurse that a patient's behavior improves immediately after the daily visit of the physician; or that the patient's conversation becomes more bizarre and fearful as night approaches; or that an association between two patients activates destructive trends in one or both; or that a roommate irritates and provokes a patient. Verbal transmission of this information is time-consuming and inaccurate because of the human element of forgetting. By writing it down, however, the objectivity of the nurse is probably increased because of the fact that the report is permanent and is available to other observers, for both nurses and physicians to see. Accurately kept daily clinical charts on each patient preserve important facts and keep the doctor informed. As one physician remarked, "Time spent with the patient is useless to others if they know nothing about it."

In a psychiatric institution in which psychoanalytic therapy is used, the charts are of particular value to the psychoanalysts in helping them to obtain an objective picture of their patient in his daily activities. While it is not always expedient to use this material directly in the analytic situation it is nevertheless good background information. To quote one analyst in our hospital, "I use the charts regularly and find them of great value, especially in the treatment of my psychotic patients. While the material is more concise in the case of my psychoneurotic patients, the charts still give me clues as to what traits make it difficult for a particular patient to make a good social adjustment." The chart is also a convenient means of checking the truth of statements made to the doctor by the patient.

In addition to the purpose of furnishing the physician with valuable data, the nurse's chart serves as very important legal evidence in difficulties involving a hospital. Among the unpleasant incidents with which every hospital must occasionally cope are the lawsuits brought by patients or relatives. Charts are admissible as evidence in most states in ascertaining the state of mind or mental attitude of

the patient at the time of an accident and in determining the facts of the occurrence in question. A full and accurate statement of the circumstances of an accident or other incident has often saved an institution from possible bankruptcy which might have resulted from an unfair damage suit. Without such records the institution is dependent for its defense upon witnesses who may be impossible to locate, or who may be forgetful or contradictory in their testimony. The hospital chart is usually admitted into evidence with only the certification and explanation of an official of the hospital who testifies to its accuracy and authenticity. This rule has been adopted by our courts because the calling of nurses and attendants to court as witnesses to authenticate the charts causes much inconvenience to the institution and to the nurse, and also because the nurse may be ill, deceased, or out of the jurisdiction of the court. Because of this possibility of referring to the charts in litigation every chart should be written as if it were going to be used as evidence in court; since it is a permanent record the very nature of which precludes alteration, the chart on leaving the ward should carry the imprint of inspection and approval of the nurse in charge.

Still an additional reason for maintaining a high standard of charting in any hospital is its indirect value in improving the nursing care and treatment. In mental hospitals it is commonly noted that where there is competent charting there is intelligent nursing, and where there is desultory charting there is a tendency to give merely custodial care. This is not difficult to understand. Nurses who learn to observe critically and comprehensively also learn to anticipate reactions and are able to forestall crises and to help patients through recurrent difficult periods. The nurse who charts is stimulated to observe the patient more closely because she must know what he is doing at each 20 or 30 minute interval. She is alert to notice slight but often important facts which are significant to the doctor in diagnosis and treatment. This is especially true if she is psychiatrically educated and functions as an understanding companion, for some patients find it difficult to talk of their emotional problems to the doctor because of diffidence or fear, but will confide frankly in their nurse. There is no doubt that the keeping of records sustains the interest of the nurse in her patient, since improvement or regression in the patient's condition can be quickly checked by comparison with the daily records from time to time. It also prevents a repetition of nursing mistakes; the

chart is the nurse's record showing that the orders given her have been carried out, and an analysis of the nursing care can be easily made by the physician by a review of the clinical record.

The specific purposes, then, of the nurse's charts in a psychiatric institution include the recording and passing on of valuable data to the physician, legal protection to the institution, and the provision of an indirect method of insuring good nursing care. It should perhaps also be mentioned that charts in any institution if correctly and adequately made are a valuable source for clinical research. This is particularly true when studies of one group of patients such as those addicted to alcohol or drugs, or those receiving special forms of treatment, are involved.

The results of a survey of a number of psychiatric nurses as to their attitude toward charting are of special interest. The majority of well adjusted psychiatric nurses have no difficulty in maintaining an objective attitude regarding the necessity for recording their observations on patients. Occasionally when there is a counter-transference the nurse is specially sensitive as to what she writes, and the majority of inexperienced nurses hesitate to report remarks about themselves by the patient. Occasionally the patient makes a request that certain information not be placed on his chart and where this involves a discussion of other nurses the nurse is hesitant as to what to do. It is the nurses' impression that most patients do resent the charting of their remarks and activities, first because they think that the nurses will misinterpret or misquote them; second, because such information will be "held against them"; and third, in some instances they seem jealous of the time spent by the nurse in charting.

Some nurses are aware of a temptation to compulsively record trivialities. This is particularly true in the case of a so-called "happily adjusted" chronic individual with whom there are no new events or unusual activities, and yet the nurse must account for the patient's time. The nurses universally desire that their charts be read; and the fact that they know that they are very greatly affects the care used in writing.

TYPES OF CHARTS

Daily Clinical Record: This chart, as indicated by its title, is made out for each 24 hour day, and should describe accurately and adequately the patient's appearance, his behavior and pertinent conversation.

It should include the usual material of the general hospital chart if this is indicated, specifically the temperature, pulse and respiration, the record of medications, and the time of visits from the physician or relatives and friends. It should carry a description of unusual events or procedures affecting the patient through the twenty-four hour period. For example, the use of some form of physical restraint is occasionally necessary in acutely excited or delirious patients. Not only should this be noted, but the nurse can protect herself and the hospital from criticism on this score by careful charting of the patient's behavior prior to the application of restraints, the name of the physician who ordered them, the person who applied them, and the conduct of the patient while in restraints, as well as the time that they were removed.

In connection with this study a survey was made of 21 psychiatric institutions—2 private, 13 state, 1 Federal, 3 city and 2 county institutions—the group covering 15 different states. Ten of these institutions reported daily notes on new or acutely ill patients, and weekly or monthly reports on all other patients. One institution reported keeping a daily summary for each ward as a ward, with no individual notes. One reported keeping daily notes on acutely ill patients only, and no charting for other patients. In regard to the quantity of charting carried out, the survey indicated that 9 institutions reported an approximate amount of from 3 lines to a page daily on each patient charted, while the others did not specify the amount.

Admission Record: Either a separate admission chart or a detailed notation on the first daily chart of every patient is very much to be desired. Shortly after admission, the patient should be carefully examined for injuries and scars on his body; all injuries and scars, however small, should be described in the record for protection in case the patient should later charge that an injury was received in the course of careless handling in the hospital. Equally careful charting should be done in regard to all injuries received at the hospital. In this connection the recording of all accidents, from the simplest bruise to a major accident, should be the unvarying rule. All witnesses to such an injury or accident should record their version of the incident and affix their signatures.

The nurse's impression of the physical condition of the patient at the time of admission should be charted very carefully. Thus, in addition to bruises or injuries or scars she should report whether the patient

appears to be toxic, acutely physically ill, dyspnoeic or cyanotic. The legal records in one state show that a patient was admitted to a mental hospital when he was in the first stages of pneumonia, from which he died three days later. This situation resulted in a law suit and because the nurse who admitted the patient had neglected to describe fully the patient's physical condition at the time of admission the institution sustained damages of several thousand dollars. Some psychotic patients will not tell the nurse when they suffer physically, and she must learn of their pain only through close observation. This admission note advisedly should record the temperature, pulse and respiration on admission, and if possible the weight.

Weight Charts: A graphic chart to show the weight has been found to be of much help, recording in some instances the daily weight, perhaps in the majority the weekly weight. In our survey of the 21 institutions mentioned above the patient's weight is recorded weekly in most of them. Two institutions recorded it monthly; one recorded it on acutely ill patients only, and in one institution no weight record was kept.

Menstruation Record: In our own institution we have found it very helpful to have a running record from month to month on the same chart, showing the dates of and reactions to menstruation. In devising this form we allowed space for the inclusive dates, any medication given, the interval since the last menstrual period, duration of the present period, the unusual aspects as to amount or character, and the emotional response that is manifest at the time. From three to six or eight months' record on the same page permits easy comparison.

Special charts: Although the need is infrequent, sometimes it is highly desirable to maintain graphic temperature charts, charts of fluid intake and output, and of sleep. Where this data is of particular importance it is difficult and in fact may be confused if it is included in the daily clinical charts, and in our own institution special forms are used when these records are desired.

Special Treatment Forms: Specially arranged forms are used for special treatment procedures, such as shock therapy and hyperpyrexia.

METHODS OF CHARTING

Frequency of Charting: In our own hospital, charting is done on each patient's chart every half hour, and in some instances oftener. All

important conversation is recorded at length if this is at all possible. This method of charting is very time-consuming, and since nearly all of the charting is done by nurses, more nurses are required than would be necessary if charting were not so detailed. It should be mentioned that several of the institutions which cooperated so helpfully in this survey remarked that they realized that a patient could be helped in treatment and diagnosis by a more complete system of charting, but because of the lack of sufficient nurses and attendants this was impossible.

In our survey of the 21 institutions we learned that in one institution the physician does all of the charting, in three others he does at least half, that the supervisor does half of all the charting in one institution and the psychiatrically trained registered nurse does all the charting in four institutions, from half to nine-tenths in nine institutions and one-tenth in one institution. The student nurse does half the charting in one institution and about one-tenth in another. The trained attendant does nine-tenths of the charting in one institution, one-fourth in two institutions, and about one-tenth in another. All of the employees do charting in three institutions.

Material to be Charted: Since the selection of the material to be charted must depend on the individual who is doing the charting, it is to be expected that that individual's training, experience and psychiatric understanding will determine the value of the charts. As has been pointed out, however, the nursing care in a considerable degree can be judged, and is correspondingly improved by the caliber of charting. The most important qualification for a good chartist is the ability to observe and to properly evaluate and interpret his observations. Next in importance is his command of an adequate vocabulary and a knowledge of sentence structure and English usage so that he may present his observations lucidly. Another highly desirable qualification which requires intelligence, concentration and practice, is the ability to select valuable material and to record only that material, instead of wasting time on repetitious and valueless details of conversation and behavior. Quality rather than quantity is to be desired in records. Concise reporting need not mean an omission of important data. No detail of the patient's conduct, attitude or appearance is insignificant and it is better to err by including too much than too little. But the good chartist learns how to sketch a vivid picture with few words, rather

than to give a vague, verbose, meandering account of the patient's activities.

The best method of acquiring psychiatric terminology is to enroll in a well conducted class on this subject, such as that provided by a few psychiatric institutions. The use of such terminology, however, must be exact or it is meaningless. The use of such terms as "paranoid behavior," or "aggressive behavior," should be avoided except when the chartist wishes to record repetitious behavior of the patient which has already been specifically described on the chart. It is always better to write out a complete description of the actions or words of the patient which led the chartist to believe that the patient was paranoid or aggressive. When such terms are used it should be with a thorough understanding of the standard sense or meaning which has been accepted for them in that institution, so that others in that hospital will know exactly what is meant. The proper selection of words to give an exact shade of meaning is very important to all concerned. Ambiguity due to misuse of words, phrases or sentence structure can cause much harm, therapeutically and legally. If symbols are used they should have a definite, standardized meaning in the institution so that they will be open to only one interpretation. The use of symbols has been discarded by many modern psychiatric institutions because they lend themselves readily to slovenly, nonspecific description. In our hospital it was found helpful to compose a manual on the "interpretation of terms" to be used both on the physicians' order sheets and on the charts, in which definite meanings for certain, much used terms are defined and discussed. The quality of the charting was much improved by the increased understanding which this "common language" facilitated.

The ability to select valuable material and to omit worthless material from the charts requires not only experience and a thorough knowledge of the institution and of the uses to which the chart will be put, but also a knowledge of the nature of psychodynamics, of abnormal psychology, of general psychology and of the patient's general history. The latter will enable the nurse or attendant to observe more discerningly the individual's reaction to certain stimuli, such as a conference with a doctor, a letter from home, a period spent in hydrotherapy, occupational therapy, or other departments, a visit from a relative or a trip to see a certain moving picture.

When describing the conduct of the individual the chartist should think first of the patient's general behavior in relation to the situation. That will enable her to gauge the degree of its deviation from what is usual. Instead of describing him as merely "unsociable" she will try to describe the amount of persistence he shows in his asocial conduct. She will mention his daily habits of personal hygiene, eating, appearance, occupation, sleeping, and note his care of personal property and his adaptation to a group. With this background she can describe with proper emphasis those things which he does which are bizarre or obviously abnormal. Evidence of delusions and hallucinations can best be given by directly quoting the patient. The same method is preferable in portraying moods, attitude and reactions, as it permits the doctor who reads the chart to make his own interpretation of the material.

It is very important to notice whether the patient's manner of speech is in harmony with his other actions. A direct quotation from the patient may be open to several interpretations unless his expression, tone of voice and behavior at the time are accurately presented. It often happens in charting that incidents and especially conversation are recorded only because of their humor, bizarreness or absurdity. The chartist should be able to distinguish these exceptional happenings from those which are truly representative. Quotations are often of great significance.

Because of the pressure of other duties, perhaps because of inexperience, the nurse may be tempted to interpret the significance of a facial expression, rather than to describe it. She may make the error of attempting to give the significance of a delusion instead of describing what she sees and hears, and leaving the interpretation to the physician. Special care in the choice of words must be used to avoid mistakes and to make fine distinctions—the differentiation between gestures and mannerisms, between illusions and delusions, between anxiety and restlessness, and between grimaces and tics, for example. The psychiatric chartist must overcome any false modesty which leads her to describe obscenity or vulgarity in speech or action other than just as she sees or hears it.

Protection of the Records: The chartist's first responsibility is to protect her records as confidential information until they leave her hands. Patients generally learn of the fact that their remarks and actions are

charted, and it is not infrequent that patients in facetious moods will make out their own charts, or even charts on the nurses. There is often a great deal of resentment felt and sometimes expressed by patients towards the nurse because of her recording notes about them. As a consequence, the patient may attempt to see these charts, perhaps to contradict them, perhaps to argue with the physician about them, or, rarely, to revenge himself on the nurse. Because of this the charts must be kept from the patients with great care.

Completed charts should be considered permanent and valuable records and they should be kept in a fireproof room under lock and key. Because of the tremendous amount of space which they consume, particularly where daily clinical records of one, two or three sheets on each patient are kept, the matter of storage becomes a problem. In our institution we have been trying out the plan of photographing the records on 16 mm. moving picture film, using the Recordak machine. It has been ruled that these films are admissible as legal evidence. The space saving is enormous, since approximately 1,750 letter-size sheets may be photographed on a 100 foot spool of 16 mm. film. In contrast to a stack of paper about 8 inches thick the finished product is 4 x 4 x 1 inches.

SUMMARY

Daily charting of the patient's attitudes, behavior and conversation has become one of the major responsibilities of the psychiatric nurse. We have discussed the purposes of charting and the various types of charts to be kept, including a brief survey of the charting methods of twenty-one institutions, and certain principles governing the writing of charts, what they should contain, who should write them and the frequency with which they should be written.

PSYCHIATRY IN RELATION TO NATIONAL DEFENSE

Seminars Held at the Menninger Clinic, June 23–28, 1941

Seminars on Selective Service System Psychiatry have recently been held at six or seven key cities throughout the country. Various members of our Staff have attended and participated in several of these; (in Atlanta, Chicago, Los Angeles, and Dallas). For the instruction and interest of our own Staff, Dr. R. P. Knight and Dr. D. W. Orr organized a seminar series at the Menninger Clinic. Besides members of our own Staff, local physicians, social workers, and members of the Local Selective Service Boards were invited.

The course as a whole was divided into three sections, as follows:

I. Selective Service System Neuropsychiatry

The purpose of this part of the course was to acquaint the Staff with the aims and methods of the Selective Service System psychiatric classification, with the special problems arising in connection with neurological and psychiatric examinations at the level of the Local Boards and the Army Induction Boards, and with special devices and techniques for conducting these examinations in minimum time.

II. Military Psychiatry

This part of the course was concerned with the management and treatment of neuropsychiatric problems of men in training and men in combat. Material was drawn from experiences of the last war and from what is available from foreign sources concerning the present war. It is here, especially, that psychiatrists can make a contribution in the application of principles of dynamic psychiatry to wartime military conditions.

III. Psychiatry for Civilians in Wartime

This part of the course concerned itself with the "home front" in wartime. Questions of civilian morale were considered as well as some of the sociopsychiatric problems of evacuation of children, of

temporary loss of wage-earners, of absence of the head of the family, and the like. Situations confronting men who are rejected by Selective Service or discharged from the Army either now or in time of actual war were also considered.

Because of the somewhat didactic nature of these seminars, each one was divided into two periods: the presentation and the discussion. Approximately 30 minutes were allowed for each period. Guests at the seminars were invited to participate in the discussions. The Staff as a group is now prepared to offer this material, as a postgraduate course, to psychiatrists working with Army Induction Boards or Medical Advisory Boards, and both the Surgeon Generals as well as the national headquarters of the Selective Service System have been informed of our willingness to repeat the seminars for the instruction of others.

The program, in detail, was as follows:

I. Selective Service System Psychiatry

Monday, June 23

4:15–5:15 Objectives of the Selective Service System Psychiatric Classification—*Dr. Douglass W. Orr*

5:15–6:15 Types to be Rejected under Present Selective Service Regulations—*Dr. Robert P. Knight*

Tuesday, June 24

1:00–2:00 The Psychiatrist in Relation to the Local Boards—*Dr. William C. Menninger*

4:15–5:15 The Psychiatrist in Relation to the Army Induction Boards—*Dr. Edward D. Greenwood*

5:15–6:15 Techniques for a Basic Psychiatric Examination—*Dr. Douglass W. Orr*

Wednesday, June 25

1:00–2:00 Detecting Schizoid and Pre-Schizophrenic Personalities—*Dr. Carl-Gustaf D. Tillman*

4:15–5:15 Detecting Psychoneurotic Personalities—*Dr. Robert P. Knight*

5:15–6:15 Detecting So-called Psychopathic Personalities—*Dr. Karl A. Menninger*

8:00–9:00 Detecting Feebleminded Registrants—*Dr. David Rapaport*

9:00–10:00 Detecting Malingerers—*Dr. Merton M. Gill*

Thursday, June 26

4:15–5:15 Techniques of a Basic Neurological Examination—*Dr. Harlan Crank*

5:15–6:15 Early Signs of the Most Common Neurological Conditions—*Dr. Lewis L. Robbins*

II. Military Psychiatry

Friday, June 27

1:00–2:00 Psychiatric Problems of Soldiers in Training and Their Treatment—*Dr. Douglass W. Orr*

4:15–5:15 Psychiatric Problems of Soldiers in Combat and Their Treatment—*Dr. Robert P. Knight*

5:15–6:15 Aviation Neuropsychiatry—*Dr. Harlan Crank*

III. Psychiatry among Civilians in Wartime and Other Problems of Morale

Saturday, June 28

8:30–9:30 Neuropsychiatric Casualties and Compensation—*Dr. Ernest Lewy*

9:30–10:30 The Analysis of Propaganda—*Dr. Sylvia Allen*

10:30–11:30 The Place of Psychological Testing in National Defense—*Dr. David Rapaport*

11:30–12:30 Civilian Morale—*Dr. Karl A. Menninger*

1:00–2:00 Psychiatric Care of Children in Wartime—*Dr. Merton M. Gill*

2:00–3:00 The Rejected Draftee in the Community—*Dr. Douglass W. Orr*

Some of these presentations will be published in the next issue of the Bulletin.

FOURTH ANNUAL SOUTHARD SCHOOL INSTITUTE

The Fourth Annual Southard School Institute was held June 2 to 13, 1941, in Topeka. Twenty-five persons enrolled for the entire course and about 50 visitors attended particular sessions.

The program:

MONDAY, JUNE 2

9:00– 9:30 Registration
9:30–10:20 Introduction—*Dr. Karl Menninger*
10:30–11:20 Normal Personality Development in Infancy (Birth to Two Years)—*Dr. Lewis L. Robbins*
2:00– 2:50 Parental Management of the Infant—*Dr. Sylvia Allen*
3:00– 3:50 Forum: Discussion of Infancy Period—Weaning, Toilet Training, Thumb-sucking, Eating Habits, Disciplinary Methods, Etc.—*Dr. Mary O'Neil Hawkins*

TUESDAY, JUNE 3

9:30–10:20 Normal Personality Development of the Pre-School Period—*Dr. Douglass W. Orr*
10:30–11:20 Psychological Factors Which Influence Development during the Pre-School Period—*Dr. Elisabeth R. Geleerd*
2:00– 2:50 Illustrative Cases: An Over-Mothered Child. An Emotionally Deprived Child—*Dr. Robert L. Worthington*
3:00– 3:50 Forum: Discussion of Personality "Inheritance"—*Dr. Carl-Gustaf D. Tillman*

WEDNESDAY, JUNE 4

9:30–10:20 Influence of Brothers and Sisters—*Dr. Douglass W. Orr*
10:30–11:20 Psychology of the Only Child—*Dr. William C. Menninger*
2:00– 2:50 Illustrative Cases: An Only Child. Sibling Rivalry—*Dr. Robert L. Worthington*
3:00– 3:50 Forum: Discussion of Problems of Spoiling, Competition, Jealousy, Loneliness, Etc.—*Dr. Anne Benjamin*
7:30– 9:00 Seminar: Summary of the Influences Conditioning Personality Development in the First Six Years of Childhood—*Dr. Mary O'Neil Hawkins, Chairman, Dr. Geleerd and Staff, Discussants*

THURSDAY, JUNE 5

9:30–10:20 Normal Transition from Home to School—*Dr. Sylvia Allen*
10:30–11:20 Typical Maladjustments—Timidity, Aggressiveness, Oversubmissiveness, Defiance—*Dr. Anne Benjamin*

2:00- 2:50 Illustrative Cases: Difficult Adjustment to School Situation—*Mrs. Ida Malcolm*

3:00- 3:50 Forum: Methods Available to Teacher in Aiding Child's Adjustment to School Situation—*Dr. Mary O'Neil Hawkins*

4:00- 4:50 Levels of Intelligence and the School Program—*Dr. Byron Sarvis*

FRIDAY, JUNE 6

9:30-10:20 The Children's World in Relation to the School Program—*Dr. Robert J. Havighurst, Professor of Education, University of Chicago.*

10:30-11:20 Teacher-Child Relationships in the School—*Dr. Robert J. Havighurst*

2:00- 2:50 Illustrative Cases—*Mrs. Ida Malcolm and Staff*

3:00- 3:50 Teacher-Teacher Relationships in the School—Forum—*Dr. Robert J. Havighurst*

7:30- 9:00 Seminar: Interpersonal Relationships in the School—*Dr. Robert J. Havighurst, Chairman; Drs. Karl Menninger, Hawkins, Knight, Discussants*

SATURDAY, JUNE 7

9:30 Developmental Tasks of the Adolescent—*Dr. Robert J. Havighurst*

MONDAY, JUNE 9

9:30-10:20 Special Problems of Home Environment—Parental Discord and Inconsistency—*Dr. Elisabeth R. Geleerd*

10:30-11:20 Special Problems of Home Environment—The Adopted Child and His Management—*Dr. Robert P. Knight*

2:00- 2:50 Suggested Recreational Program for the Maladjusted Child—*Dr. Edward D. Greenwood*

3:00- 3:50 Illustrative Cases: Psychogenic Retardation—*Dr. Anne Benjamin*

TUESDAY, JUNE 10

9:30-10:20 Sexual Development—Infancy through Adolescence—*Dr. William C. Menninger*

10:30-11:20 Sexual Deviate Behavior and Its Management—*Dr. Robert P. Knight*

2:00- 2:50 Illustrative Cases: Sexual Symptoms—*Dr. Merton M. Gill*

3:00- 3:50 Forum: What Are the Normal Limits of Sexual Behavior in Children?—*Dr. Sylvia Allen*

WEDNESDAY, JUNE 11

9:30-10:20 Parent-Teacher Relationships—*Dr. Malcolm H. Finley, Psychiatrist to the public schools, Winnetka, Illinois.*

10:30-11:20 Social Development of the Preadolescent Child—*Dr. Malcolm H. Finley*

2:00- 2:50 The Child Whose Intelligence Is Inhibited by Emotional Conflicts—*Dr. Carl-Gustaf D. Tillman*

3:00- 3:50 Emotional Factors in Academic Problems: The Non-Reader Pupil of Good Intelligence but Poor School Work—*Dr. Malcolm H. Finley*

7:00- 9:00 Special Problems of Adolescence—*Dr. Karl Menninger, Chairman; Dr. Finley, Miss Anne Laughlin, and Staff, Discussants*

THURSDAY, JUNE 12

9:30–10:20	Speech Disorders—Mental and Physical Aspects—*Dr. Mary O'Neil Hawkins*
10:30–11:20	Physical Illness and the Emotional Components—*Dr. Merton M. Gill*
2:00– 2:50	Illustrative Cases: Obsessional Reactions and Anxiety States—*Dr. Elisabeth R. Geleerd*
3:00– 3:50	Forum: Discussion of Delinquency—*Dr. Lewis L. Robbins*

FRIDAY, JUNE 13

9:30–10:20	Maladjustments—Early Signs of Mental Illness—*Dr. Douglass W. Orr*
10:30–11:20	The Function of Education in the Promotion of Mental Health—*Dr. Karl Menninger*
2:00– 2:50	Review
3:00– 3:50	Examination
4:00	Picnic

RESIDENCIES IN NEUROPSYCHIATRY

Four residencies per year are approved by the Council on Medical Education and Hospitals of the American Medical Association for the Menninger Sanitarium. Appointments for January and July 1942 are now being considered.

Minimum requirements:	**Graduation from an approved medical school**
	Completion of an internship in an approved hospital
	Candidates with psychoanalytic training preferred
Didactic instruction includes:	**Conferences with staff members**
	Seminar discussion group
	Staff conferences
	Postgraduate courses for nurses and physicians
	Class work in neurology, neuropathology, psychiatry and psychoanalysis

Address inquiries to

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BOOK NOTICES

Must We Grow Old? By BARCLAY NEWMAN. Price $2.50. Pp. 269. New York, G. P. Putnam's Sons, 1941.

This is a popular presentation of the new point of view in hygiene, namely, that death and old age can perhaps be deferred much more than we now expect by an extension of scientific investigations of recent discoveries and an application of them to human living. (K. A. M.)

From Thirty Years With Freud. By THEODOR REIK. Price $2.50. Pp. 241. New York, Farrar & Rinehart, Inc., 1940.

In this series of letters, essays and comments Reik endeavors to convey something of his own intimate veneration of Freud to the lay reader. The book lacks Freud's simplicity, his courage and his modesty but it breathes the same sincerity, honesty and scientific curiosity and it sets forth sympathetically and accurately certain of Freud's ideas and attitudes. It is not a systematic or comprehensive treatise, but is rather a collection of essays of which the "Memories of Sigmund Freud" is the best and the discussion of Dostoyevsky perhaps the most interesting. (K. A. M.)

Your Child's Food. By MIRIAM E. LOWENBERG. Price $2.50. Pp. 290. New York, McGraw-Hill Book Co., 1939.

This is a commendable book for mothers and nursery school workers who need help with the problems of what and how to feed the child. The author gives practical information and guidance in the solution of these problems as a result of her studies and experiences with children in the nursery school at Iowa State College. (L. F. H.)

Sex in Development. By CARNEY LANDIS. Price $3.75. Pp. 329. New York, Paul B. Hoeber, Inc., 1940.

This is a statistical analysis of results obtained from a questionnaire approach to conscious memories and attitudes regarding sexual experience conducted by a group of psychologists at the N. Y. Psychiatric Institute. 153 normal and 142 institutionalized women were interviewed. The results were compared with anatomical findings made by three physicians connected with the College of Physicians and Surgeons. The authors feel that their statistical findings support the findings and deductions of Freud in some respects and fail to support them in others. (K. A. M.)

Personality and Life. By Louis P. Thorpe. Price $2.50. Pp. 266. New York, Longmans, Green & Co., 1941.

This is a simple presentation of personology by a professor of education assisted by an instructor in psychology. It is intended for college students and it is occupied with such questions as, "When are we emotionally mature?" "How can we become as others like us?" "Is there a psychological foundation for social planning?" What the authors themselves have to say, while elementary, is adequate, but the bibliographic references lean heavily on such "authorities" as Henry C. Link, Alexis Carrel, Alfred Adler, V. E. Fisher (the author of "Auto-correctivism") and F. L. Ruch. (K. A. M.)

Congenital Syphilis. By C. C. Dennie and Sidney F. Pakula. Price $8.00. Pp. 596. Philadelphia, Lea & Febiger, 1940.

This is a treatise of nearly 600 pages on all phases of congenital syphilis. The material is very well organized, taking up in twenty chapters the various systems and types of congenital syphilis with an extensive chapter on treatment. The book is well-documented throughout each chapter with references to the literature. (W. C. M.)

American Doctors of Destiny. By Frank J. Jirka. Price $3.75. Pp. 361. Chicago, Normandie House, 1940.

Jirka presents biographical assays of twenty outstanding American physicians accompanied by full page portraits. It is written in a lively style with no attempt at detailed documentation. (K. A. M.)

Faith is the Answer. By Smiley Blanton, M.D., and Norman Vincent Peale, D.D. Price $2.00. Pp. 223. New York, Abingdon-Cokesbury Press, 1940.

This is a collaboration by a psychoanalytically trained psychiatrist and a minister in the discussion of such topics as conscience and the sense of guilt, grief and sorrow, love and marriage. Each chapter consists of two parts, a discussion of the topic by the psychiatrist and a discussion of the same topic by the minister. It is replete with illustrations and its encouraging, reassuring tone makes it an excellent book for patients, especially those for whom the conflict between religion and science is painfully acute. (K. A. M.)